STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G015	A. BUILDING _____ B. WING _____	R 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RUN/ROBIN'S NEST GROUP HOME	3845 ROBIN'S NEST ROAD LA GRANGE, NC 28551

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A revisit was conducted on 9/16/2021 for all previous deficiencies cited on 5/25/2021. All deficiencies have not been corrected and new noncompliance was found. The facility is not in compliance with all regulations surveyed.	W 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider or the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.	10.15.2021
W 130	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(7) The facility must ensure the rights of all clients. Therefore, the facility must ensure privacy during treatment and care of personal needs. This STANDARD is not met as evidenced by: Based on observations, record review and interview, the facility failed to ensure privacy during personal care for 1 of 2 audit clients (#5). The finding is: During morning observations in the home on 9/16/21 at 8:10am, client #7 was observed using sitting on the toilet. At 8:11am, Staff B gave a verbal prompt to another client to go into the bathroom while client #7 was still sitting on the toilet. Further observations revealed the other client was putting some dirty clothes into the washing machine, which is located in the bathroom. During an immediate interview, Staff B revealed no other clients should be told to go into the bathroom while client #7 was using the bathroom. During an interview on 9/16/21, the qualified intellectual disabilities professional (QIDP) confirmed while client #7 was in the bathroom, no other clients should have went in.	W 130	Staff will be in-serviced on client's right and the need to ensure privacy during treatment and care of personal needs. Team to meet to discuss possible new objective for individuals to knock before entering a bathroom which will be completed by the HS. Informal monitoring to occur through daily observations by QP, Group home Manager and/or HS. Formal monitoring to occur at least monthly through completion of the Interaction assessment. DHSR - Mental Health OCT 04 2021 Lic. & Cert. Section	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 9.30.2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	34G015	A. BUILDING _____ B. WING _____	R 09/16/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FOX RUN/ROBIN'S NEST GROUP HOME	3845 ROBIN'S NEST ROAD LA GRANGE, NC 28551

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{W 137}	PROTECTION OF CLIENTS RIGHTS CFR(s): 483.420(a)(12) The facility must ensure the rights of all clients. Therefore, the facility must ensure that clients have the right to retain and use appropriate personal possessions and clothing. This STANDARD is not met as evidenced by: Based on observations, interviews and record review, the facility failed to ensure 1 of 2 audit clients (#7) had the right to appropriate fitting clothing. The finding is: During observations in the home on 9/16/21 client #7 was observed wearing a pair of jeans which did not fit properly, from 8:00am until 8:50am. Further observations revealed client #7's blue jeans were hanging very low on her hips, with her stomach and buttocks visible. At 8:35am, client #7 the qualified intellectual disabilities professional (QIDP) pulled up client #7's pants within view of other clients while standing in the living room; but the jeans slid back down. Further observations revealed client #7 was not wearing a belt. During an interview on 9/7/21, Staff A revealed client #7 gets assistance with dressing on third shift. Further interview revealed client #7 received some new clothes in the past few months. Staff A also stated today is the day for client #7 to wash her dirty clothes. Review on 9/16/21 of client #7's adaptive behavior inventory (ABI) dated 1/18/21 stated, "Requires supervision from staff to ensure proper choices are made."	{W 137}	Staff will be in-serviced on objective for client #7 to pick out clothes that are comfortable and fit appropriately. Staff will be in-serviced to assist client #7 when picking out her clothes to ensure they are comfortable and fit appropriately. Staff will be in-serviced to prompt individuals to adjust clothing independently and if they refuse, staff will assist them to a private area to assist with adjusting their clothing Informal monitoring to occur through daily observations by QP, Group home Manager and/or HS. Formal monitoring to occur at least monthly through completion of the Interaction assessment and appearance checklist.	10.15.2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	34G015	A. BUILDING _____ B. WING _____	R 09/16/2021

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FOX RUN/ROBIN'S NEST GROUP HOME	3845 ROBIN'S NEST ROAD LA GRANGE, NC 28551

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{W 137}	Continued From page 2 Review on 9/16/21 of the facility's Plan of Correction (POC) revealed client #7 has a new dressing goal which was implemented on 7/4/21. During an interview on 5/25/21, the administrator stated the facility will follow up with ensuring client #7's goal is being implemented.	{W 137}		
W 340	NURSING SERVICES CFR(s): 483.460(c)(5)(i) Nursing services must include implementing with other members of the interdisciplinary team, appropriate protective and preventive health measures that include, but are not limited to training clients and staff as needed in appropriate health and hygiene methods. This STANDARD is not met as evidenced by: Based on observations, documentation and interview, nursing services failed to ensure that staff were sufficiently trained in the taking the temperature of visitors in regards to COVID-19 protocol. This potentially effected all clients (#1, #2, #3, #4, #5 and #6) residing in the facility. The finding is: During morning observations in the home on 9/16/21 at 8:00am, Staff A opened the door at let the surveyor in. Further observations revealed the surveyor's temperature was not taken. Additional observations revealed there was a thermometer on the counter in the kitchen. The surveyor's temperature was not taken until 8:47am; in the time the surveyor has come into contact with two staff and six clients. During an interview on 9/16/21, the home	W 340	Staff will be in-serviced on the COVID-19 protocol and ensure all screenings on visitors have been completed prior to entering the home and if not completed will ensure visitors complete the screening form and their temperatures are taken appropriately. Informal monitoring to occur through daily observations by QP, Group home Manager and/or HS.	10.15.2021

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W 340	Continued From page 3 supervisor (HS) revealed staff have been trained to ensure all visitors temperatures are taken. During an interview on 9/16/21, the administrator revealed the surveyor should had been directed to the main building to have their temperature taken.	W 340		
W 454	INFECTION CONTROL CFR(s): 483.470(l)(1) The facility must provide a sanitary environment to avoid sources and transmission of infections. This STANDARD is not met as evidenced by: Based on observations, interviews the facility failed to ensure proper infection control procedures were followed in order to promote client health/safety and prevent possible cross-contamination. This potentially affected all clients (#1, #2, #3, #4, #5 and #6) residing in the home. The findings are: A. During breakfast observations in the home on 9/16/21 at 8:08am, client #3 poured some milk into her glass which she has previously drank from. Further observations revealed client #3 drinking some of the milk and then pouring the remainder into the glass of client #7. Client #7 then drank the milk from her glass. At no time was client #7 prompted not to drink from her glass. During an interview on 9/16/21, Staff B stated she did not see client #3 pour the milk into client #7's glass and client #7 then drinking from it. During an interview on 9/16/21, the qualified	W 454	Staff will be in-serviced on the infection control procedure and the need to provide a sanitary environment to avoid sources and transmission of infections. Informal monitoring to occur through daily observations by QP, Group home Manager and/or HS. Formal monitoring to occur at least monthly through completion of the meal time assessment.	10.15.2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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W 454	Continued From page 4 intellectual disabilities professional (QIDP) revealed the glass of client #7 should have been replaced with a clean one. B. During morning observations in the home on 9/16/21 at 8:37am, client #3 removed a bag of trash from a trash can, took it outside, put into the trash can outside. Client #3 then came back into the house. Additional observations revealed client #3 did not wash her hands. Further observations revealed client #3 was not given any prompts to wash her hands. During an interview on 9/16/21, the QIDP stated client #3 should have been given prompts to wash her hands after she handled the trash.	W 454		

RHA
HEALTH SERVICES, LLC

September 22, 2021

Eugina Barnes
Mental Health Licensure and
Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

Dear Ms. Barnes,

Enclosed is the Plan of Correction for the deficiencies noted during the follow-up survey completed on September 16, 2021 for Fox Run and Robin's Nest.

Please feel free to contact me with any questions or concerns. We look forward to seeing you soon for the follow-up.

Respectfully,

Tara Nicki Ethridge

Tara "Nicki" Ethridge, RN
Administrator

The original forms were completed & mailed on Friday 9.24.21 however I was on vacation @ that time and the acting Administrator did not sign the form.

NC DEPARTMENT OF
HEALTH AND
HUMAN SERVICES

ROY COOPER • Governor
MANDY COHEN, MD, MPH • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

September 17, 2021

Ms. Nikki Etheridge, Administrator
RHA Health Services NC, LLC
5840 Greenwood Ave.
LaGrange, NC 28551

Re: Follow-up Survey Completed September 16, 2021
Fox Run/Robin's Nest Group Home, 5840 Greenwood Ave., LaGrange, NC 28551
Provider Number 34G 015
MHL# 054-141 and MHL# 054-142
E-mail Address: netheridge@rhanet.org
nethridge@rhanet.org

Dear Ms. Etheridge:

Thank you for the cooperation and courtesy extended during the follow-up survey completed on September 16, 2021.

As a result of the follow-up survey, it was determined that deficiencies have been cited, which is reflected on the enclosed CMS-2567.

Enclosed you will find all deficiencies cited listed on the Statement of Deficiencies Form (CMS-2567). The purpose of the Statement of Deficiencies is to provide you with specific details of the practice(s) that do not comply with regulations. You must develop one Plan of Correction that addresses each deficiency listed on the CMS-2567 form and return it to our office within ten days of receipt of this letter. Below you will find details of the type of deficiencies found, the time frames for compliance and what to include in the Plan of Correction.

Type of Deficiencies Found

- Cited standard level deficiencies during this follow-up survey.

Time Frames for Compliance

- Re-cited standard level deficiencies must be ***corrected*** within 30 days from the exit of the survey, **October 16, 2021.**
- Cited standard level deficiencies must be ***corrected*** within 60 days from the exit of the survey, **November 16, 2021**

What to include in the Plan of Correction

- Indicate what measures will be put in place to ***correct*** the deficient area of practice (i.e. changes in policy and procedure, staff training, changes in staffing patterns, etc.).

- Indicate what measures will be put in place to ***prevent*** the problem from occurring again.
- Indicate ***who will monitor*** the situation to ensure it will not occur again.
- Indicate ***how often*** the monitoring will take place.
- Sign and date the bottom of the first page of the CMS-2567 Form.

Make a copy of the Statement of Deficiencies with the Plan of Correction to retain for your records. ***Please do not include confidential information in your plan of correction and please remember never to send confidential information (protected health information) via email.***

Send the original completed form to our office at the following address within 10 days of receipt of this letter.

Mental Health Licensure and Certification Section
NC Division of Health Service Regulation
2718 Mail Service Center
Raleigh, NC 27699-2718

A follow up visit will be conducted to verify all deficient practices have been corrected. If we can be of further assistance, please call Eugina Barnes at 919-819-8182.

Sincerely,

Eugina Barnes

Eugina Barnes, BSW, QIDP
Facility Compliance Consultant I
Mental Health Licensure & Certification Section

Enclosures

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DHSR@Alliancebhc.org
DHSRreports@eastpointe.net
_DHSR_Letters@sandhillscenter.org
Leza Wainwright, Director, Trillium Health Resources LME/MCO
Fonda Gonzales, Interim Quality Management Director, Trillium Health Resources LME/MCO
File